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FEBRUARY, 1954

143D ANNUAL MEETING . . .

THE RHODE ISLAND MEDICAL SOCIETY

May 5 and 6, 1954

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The RHODE ISLAND MEDICAL JOURNAL

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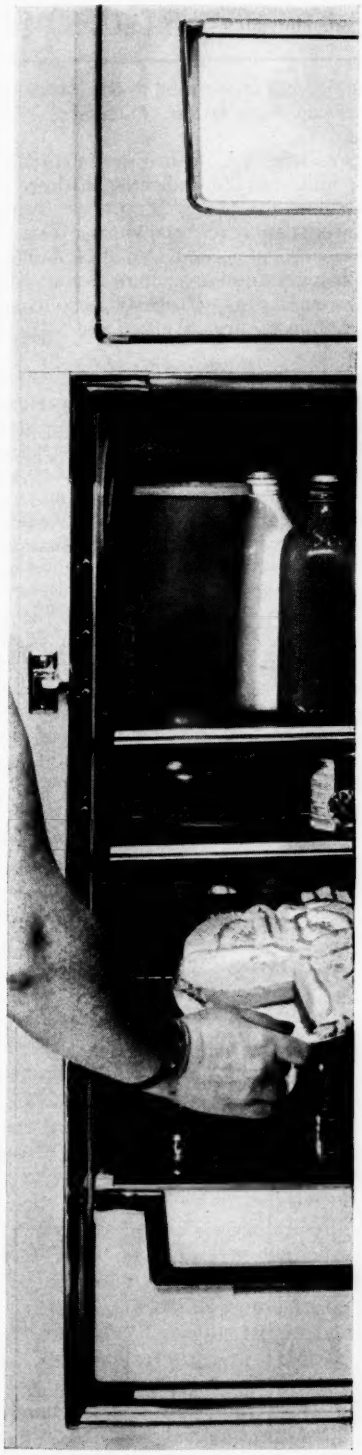

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MILK COMMISSION REPORT — PROVIDENCE MEDICAL ASSOCIATION, 1953

CERTIFIED MILK in Providence during 1953 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Hampshire Hills Farm, Wilton, N. H.; Hillside Farm, Cranston, R. I.

Through the courtesy and cooperation of the Boston Commission we have accepted their certification of one farm from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

This Commission, one year ago, discontinued the sale of Raw Certified Milk in the Providence market to conform with the standards in most of the larger cities. The legal standard for Pasteurized Certified milk is still 500 colonies per c.c. and the actual count on all samples examined by this Commission the past year was 23 colonies per c.c. The prepasteurized count on this milk must be under 10,000 and the actual count was 2,845 colonies per c.c. The credit for this splendid record belongs to the producers for their integrity and hard work.

Vitamin D Certified Milk is defined as whole Certified Milk rendered antirachitic by irradiation or by the addition of a concentrate and shall be of sufficient vitamin potency to show, by biological assay, a content of at least 400 U.S.P. units per quart.

The Wisconsin Alumni Research Foundation of Madison, Wisconsin, is doing the assaying of Vitamin D from Hillside Farm and the results have been entirely satisfactory. Four tests per year are required by this Commission.

Certified Fat-free (Skim) Milk, containing not more than 0.05 per cent butter fat, and with vitamin A added has conformed to the standards set by the American Association of Medical Milk Commissions.

The presence of Coliform organisms in unpasteurized milk usually indicates unclean milking, contaminated utensils or improper handling of milk. Rarely they may come from infected udders. Their presence in pasteurized milk indicates improper pasteurization or contamination of the milk after pasteurization. Properly pasteurized milk should contain no organisms of the coli-areogenes group.

Certified milk shall have a coliform colony count of not more than 10 per ml. before pasteurization and must be less than 1 per ml. in route samples as delivered to consumers. During the past year practically all of the samples examined in our Laboratory have conformed to this regulation.

The American Association of Medical Milk Commissions in their Methods and Standards for the Production of Certified Milk, require that each producer shall make or have made, once per month, a titration of Brucella agglutinins in the whey of the milk, whether the milk is raw or pasteurized. All titrations on the whey of the milk obtained from raw milk from Hillside Farm during the past year have been negative.

The Commission is indebted to Professor Stuart of Brown University for his continued cooperation in supervising our laboratory work at Brown University.

FRANK I. MATTEO, M.D., *Chairman*
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MONTHLY AVERAGES OF CERTIFIED MILK FOR 1953

	CHERRY HILL H. P. HOOD			HAMPSHIRE HILLS			HILLSIDE FARM								
	Pasteurized			Pasteurized			Pasteurized			Skimmed with Vit. A & D			Raw		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	3.8	12.25	2	3.9	12.50	6	3.9	12.49	29				4.0	12.53	4,400
February	3.8	12.46	2	3.9	12.52	3	4.2	12.65	32				4.1	12.70	3,100
March	3.9	12.30	11	3.9	12.39	51	4.0	12.60	30				3.8	12.16	3,800
April	3.7	12.23	2	3.9	12.54	69	3.9	12.44	34				4.0	12.75	6,000
May	3.8	12.33	3	3.9	12.48	7	3.9	12.54	14			34	4.4	12.98	2,800
June	3.8	12.41	5	4.0	12.66	114	4.0	12.62	32	0.7	9.09	268			
July	3.8	12.16	24	3.9	12.34	65	3.9	12.18	15	.5	8.7	182	3.7	12.07	127
August	3.8	12.12	44	4.0	12.34	24	3.9	12.09	22	.6	8.78	140	3.6	11.95	2,500
September	3.8	11.90	11	4.0	12.31	7	3.8	12.31	12	.2	8.74	187			
October	4.0	12.48	21	4.1	12.72	32	4.2	12.77	20	.5	8.75	35	4.1	12.82	3,580
November	3.8	12.35	29	4.1	12.70	19	3.9	12.38	12			287			
December	3.9	12.44	9	4.2	12.84	10	3.6	12.00	10			13	3.6	12.10	2,300
Yearly Average	3.8	12.28	14	3.9	12.52	34	3.8	12.44	22	.5	8.81	143	3.9	12.49	2,845

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVII FEBRUARY, 1954 NO. 2

CANCER PREVENTION*

E. CUYLER HAMMOND, D.Sc.

The Author. *E. Cuyler Hammond, D.Sc., Biometrician and Professor of Biometry, Yale University; Director, Statistical Research Section, American Cancer Society; Director, American Cancer Society's Research Project on Lung Cancer.*

E. Cuyler Hammond, D.Sc., is a biometrician and Professor of Biometry at Yale. He is a graduate of the Johns Hopkins School of Public Health, and at present is associated with the American Cancer Society in many branches of its statistical work regarding cancer, especially the study of cancer of the lung. One of his chief pieces of work is a study of the medical results at Hiroshima and Nagasaki. Although this talk was written for and presented to a lay audience at the Annual Meeting of the Rhode Island Cancer Society, we feel that it is so good that it would be well worth while to have our medical readers get the benefit of it.

— THE EDITOR

THE SUBJECT of cancer has many facets: The *acute problem*—over 230,000 Americans are slated to die of cancer in the coming year.

The *economic problem*—cancer costs the community billions of dollars a year and leaves destitute the families of thousands of its victims.

The *emotional impact*—the disease causes unparalled fear and suffering.

The *long range problem*—if present trends persist, one in five of us, perhaps you or I or both of us, will some day develop cancer.

The prevention problem

All of these cry for attention and none of them can be ignored. Therefore, we must deploy our limited forces wisely so as to ameliorate present suffering insofar as possible while pushing the attack to find a final solution for the future.

At the most pitifully hopeless level, we do what is within our power to comfort and succor victims in advanced stages of the disease who are beyond the possibility of cure by present methods of treatment. It is dreadful to contemplate that about three-quarters of those stricken by cancer today eventually reach this stage. Their distraught families too are in need of help.

*Presented at the Annual Meeting of the Rhode Island Cancer Society, at the Crown Hotel, Providence, Rhode Island, December 2, 1953.

Fortunately, all cases do not reach the terminal stage. Currently, about one-quarter of those who get cancer are being saved by modern methods of surgery and radiation therapy. In cooperation with the American College of Surgeons, other professional societies, and public health departments, we aim to see that all cancer patients receive the most effective treatment known to science today. This is being carried out through professional education, the development of new facilities, and the establishment of cancer programs in qualified hospitals.

The fact that only one-fourth, 25%, of all cancer victims are currently being saved may come as a shocking surprise to some of you. It is a matter of great distress to all of us. This is all the more distressing when you consider that a great many more could be saved by earlier diagnosis. Learning and heeding the cancer danger signals will measurably improve the patient's chances of a cure for many types of cancer. These may be called the rattlesnake types—they give warning an instant before the fatal stroke. Unfortunately, some types, like the copperhead snake, strike without warning to the victim. Many, though not all, of the latter type can be discovered very early by medical examinations coupled with such techniques as x-ray and cytological examinations. For these reasons, we devote much of our energy to lay education and cancer detection programs.

By the methods just outlined—education, detection examinations, and the most effective use of present methods of treatment—we may be able to save an additional 25% of those who develop cancer. That would be no mean accomplishment—76,000 more lives saved each year. You would not think it unimportant if one of the 76,000 happens to be you or your wife or your mother or your child. It would be a glorious achievement, but it would not be enough; not nearly enough. There would still remain the 50% of cancer victims who cannot be saved by present methods. This is our greatest challenge of all; the challenge of a future free of the fear of cancer.

That hope, shared by all of us, lies in research.

Once again we are faced with the problem of deploying our forces. Our resources are limited

continued on next page

not only in terms of money but also in terms of trained scientific manpower. Where should we center our attack? Through research we may develop more effective methods to use at each of the following points along the line:

The prevention of pain for those who are doomed to die;

The prevention of death, even in advanced cases, by new methods of treatment;

The prevention of widespread incurable cancer by new methods of detection and diagnosis;

And, finally, the prevention of cancer itself by the discovery and elimination of its causes.

All of these points are vitally important. I am sure that you have heard much about our program to discover more effective methods of diagnosis and cure. Tonight, I would like to tell you of some of the work being done in the prevention of cancer. Perhaps it is the most difficult of all our many problems, but you will agree that complete prevention would be the happiest of solutions.

Fortunately, even today we know how to prevent cancers of certain types and are doing so effectively.

Many years ago in England, a study of death reports revealed that chimney sweeps had an extraordinarily high incidence of cancer of the scrotum. This was correctly attributed to the coal soot to which they were constantly exposed. The introduction of more modern methods of cleaning chimneys eliminated the hazard and this stands as the first dramatic example of what can be accomplished by cancer prevention.

More important, this initial observation led to the discovery, through animal experimentation, that a number of chemical compounds derived from coal tars and mineral oils are capable of producing cancer. These are known as carcinogenic agents. A potent danger from such agents is presented by the remarkable expansion in recent years of the chemical and oil industries which are constantly developing new compounds for our use. The extent of the danger first became apparent in the chemical industry when it was found that workers exposed to certain aniline dyes developed cancer of the bladder. This problem was solved by the introduction of proper methods of industrial control. Today, many major oil and chemical companies routinely have tests made on new, possibly dangerous compounds to discover whether or not they are carcinogenic before they are put into production. If they are found to be so, steps are immediately taken to protect both the workers and the public.

For the last several years this activity has been encouraged and coordinated by the Cancer Prevention Committee, an association of laboratory research workers, industrial physicians, and statisticians. We meet regularly for the exchange of information and the discussion of new methods of approach. Furthermore, the Committee serves as a clearing house to put industrial concerns with a possible cancer hazard in touch with research workers who can solve it for them.

This sort of work is not dramatic. Prevention never is. It is far more exciting to watch firemen carrying people from a blazing tenement than to gaze at a modern fireproof apartment house. I cannot even tell you how many lives have been saved by this activity. But I hate to think of how many more lives might have been lost to cancer if through lack of such precautions certain new chemical products had been widely distributed for use by the general public.

Carcinogenic chemicals derived from coal tar products are by no means the only possible cause of cancer. Indeed it seems extremely unlikely that they could be the major cause of the hundred of thousands of cases of human cancer which develop throughout the world each year. Other chemicals, both organic and inorganic, are no doubt involved in at least some cases and many other factors may play a part. For example, among those which have been suggested are: inherited susceptibility; spontaneous and induced mutations; disturbance in sex hormones; virus infections; chronic irritation; and cosmic radiation. My own personal guess is that cancer is not a single disease but several different diseases with different causes. Furthermore, it seems more likely than not that most human cancers are caused by a combination of factors rather than by one factor operating alone. For example, some cancers may be due to an inherited susceptibility coupled with exposure to some inhaled or ingested chemical substance. The fact is that, except in certain industrial groups, we are not sure where to look and therefore must consider all possibilities.

Under the circumstances, one of the most hopeful procedures is to study cancer as it occurs in population groups living under various different environmental conditions as well as to compare cancer incidence in different racial groups living in the same environment. Obviously, this work has to be carried out simultaneously in many different parts of the world. It is equally obvious that in order to do so, it is necessary to be able to compare diagnoses made by doctors in many different places. That is to say, they have to speak the same scientific language.

Because the location of a cancer is so important in its treatment, it has been customary to diagnose and report cancer according to the primary site of the disease. However, it seems likely that the histologic type of a cancer may be equally impor-

tant if not more important from the standpoint of studying causation. This is determined by a pathologist looking at a bit of cancer tissue under a microscope. Unfortunately, there is no uniformity in the terminology used in describing various histologic types of cancer. Pathologists use a variety of different terminologies depending upon where they went to medical school, their nationality and their personal preferences.

It was our opinion that the first important step in the wide-scale study of cancer epidemiology would be to bring some order out of this chaos of nomenclature. To this end, we began by studying the terminology used in pathologic reports of over 30,000 cases of benign and malignant tumors. In order to get wide coverage, we collected them from tropical Puerto Rico as well as from various parts of the continental United States. Following this a systematic, uniform classification was developed for the reporting of cancer by histologic type. This work was published by the American Cancer Society in 1951 in a volume entitled MANUAL OF TUMOR NOMENCLATURE AND CODING. Much to our gratification, it was quickly incorporated, with minor editorial changes, into the American Medical Association's STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS and was later recommended by the World Health Organization for trial throughout the world. Last summer, at an international meeting I attended in Copenhagen, the MANUAL, with relatively slight modifications, was tentatively adopted as an international standard. We plan to print copies of the revised edition in five languages for presentation at the International Cancer Research Congress in Brazil next summer. It now appears as though we are nearing international agreement on this highly complex and important technical problem. This will open the way for more effective exchange of information and wider cooperation on both a national and an international scale.

I regret that I do not have time to tell you about plans for some of these international studies. I have just enough time left to discuss briefly the problem of finding means of preventing lung cancer.

Although the number of deaths from cancer in the United States has been increasing every year, most of the increase has been due to the growth and aging of our population. Of all sites of the disease, lung cancer is the only one which has shown a very large and rapid increase in age adjusted death rates over the last several decades. Both the number of deaths and the rate of increase is much greater among men than among women and reported death rates from lung cancer are higher in urban than in rural areas.

In searching for an environmental factor which might be responsible for the increase in lung cancer, one might be suspicious of any substance which exhibits all or most of the following characteristics: a) something inhaled into the lungs, particularly if it contains chemicals which can produce tumors in experimental animals; b) something to which a great many people are exposed in all parts of Europe and the United States; c) something to which people have been increasingly exposed during the last several decades; d) something to which more men than women are heavily exposed; and e) something to which city dwellers are more heavily exposed than country dwellers.

On the basis of these considerations alone, the finger of suspicion would seem to point straight to no less than three factors; namely, 1) air pollution from coal and oil furnaces, 2) exhaust fumes from automobiles, and 3) cigarette smoking. It has been known for many years that coal soot can produce human cancer and it has recently been shown that an idling automobile motor gives off no less than one milligram of a known carcinogenic substance every minute. Tar from cigarette smoke has been used to produce tumors on the skin of experimental animals.

No one of these three suspects can be exonerated at the present time and perhaps all are partially guilty. However, in the last few years, the greatest attention has been given to cigarette smoking as a possible cause of lung cancer. The argument has been waged with considerable heat in both the lay and the professional press.

What really concerns us, from a practical standpoint, is whether or not cigarette smoking (or one of the other factors) causes a really appreciable number of cases of lung cancer. In my opinion, there is not yet sufficient evidence to draw positive conclusions, particularly as to the magnitude of the effect. However, I hope to have the answer within two years from now from a study we began in the Fall of 1951. Starting in January of 1952, 22,000 volunteer researchers of the American Cancer Society obtained records of the smoking habits of over 200,000 men between the ages of 50 and 69. Annually, from that time on, the volunteers have been reporting to us on the status of each man under study; that is, they have been reporting whether he is dead or alive on a specified date and, if dead, the date and place of death. When a man is reported dead, we ascertain the cause of death from the death certificate supplied to us by the health department. If the death certificate indicates cancer, then we obtain additional, more detailed, information from the doctor or from hospital records.

By the third follow-up, we hope to have enough information to determine with certainty whether or not smoking habits are related to the development of lung cancer and the extent of the relation-

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THE GOLDEN MENACE—OR THE STAPH. OF DEATH*

ALEX M. BURGESS, SR., M.D.

The Author. *Alex M. Burgess, Sr., M.D., of Providence, R. I., Area Division Chief in Medicine, U. S. Veterans Administration.*

Dr. Alex M. Burgess, Sr., formerly chief of the medical staff at the Rhode Island Hospital, is now the Area Division Chief in Medicine for the U. S. Veterans Administration. He has been for a long time one of the editorial board of the Rhode Island Medical Journal. This word of warning, printed below, coming from one so well situated to observe medical development, is timely and important. THE EDITOR

ALMOST TWENTY YEARS after the discovery of penicillin by Fleming, in 1925, and nearly ten years after its clinical potentialities had been pointed out by Florey and his associates, we had reached a point at which, due to the marvel of mass production, it looked as if man's victory over most of the vicious varieties of the gram-positive cocci was decisive. But Mother Nature, always impartial in her attitude toward living beings, be they micrococci, mice or men, has a way of maintaining a balance. This she has been doing and is making definite progress toward neutralizing the apparent victory of the human species. After ten years of penicillin, what do we see? Certain organisms have been able to develop an effective defense against this and other antibiotics so that they can continue their depredations as of old. The best known example of this situation is the case of the tubercle bacillus *versus* streptomycin. The difficulties caused by the survival and spread of resistant forms of tubercle bacilli is familiar to all.

Now a situation of equal importance is presented in which the culprit is one of the best known of all pathogens—staphylococcus pyogenes aureus, producer of golden pigment, who goes under the new name of micrococcus pyogenes, variety aureus. This versatile micro-organism, which we know well as the commonest etiological factor in boils, carbuncles, osteomyelitis, pyemia, fulminating post-influenzal pneumonia, food poisoning and many other conditions, unfortunately for our species, has been able to acquire a high degree of resistance, not only to penicillin but to all other antibiotics. These antibiotics had previously been used effectively against it in clinical conditions, but now, in an increasing number of instances, they have been found useless, or worse than useless. The situation constitutes a health menace of major importance.

Studies conducted in this country, Canada, Great Britain, Scandinavia and elsewhere all point out the high percentage of resistant strains that are found in the general population, particularly in hospital personnel. Finland and Haight,[1] for example, studied five hundred strains of m. pyogenes obtained from all possible sources in the Boston City Hospital between October 1951 and February 1952. They found about three-quarters of them to be resistant to penicillin, one-quarter to chlortetracyclin (aureomycin) and one-third to oxytetracyclin (terramycin). In studies reported since that date, other investigators have demonstrated as high as eighty per cent of resistant organisms in hospital populations. It has been shown that ward nurses and attendants especially become carriers of such cocci, particularly in their noses, and are apparently the means of spreading the infection among patients.

This situation has also given rise to a relatively new clinical entity — staphylococcal ileo-colitis. This condition, formerly very rare, has supervened in a number of instances in which antibiotics have been given freely for other conditions, or merely as prophylaxis. Perhaps the most striking examples of this are those in which, following the prophylactic use of antibiotics in connection with simple tooth extraction, fatal ileo-colitis has occurred.[2] Fortunately, all cases have not been fatal. There have, indeed, been reports of spectacular improvement and cure in patients with this disorder, following the use of the relatively new antibiotic erythromycin; but here our victory is likely to be short-lived. Evidence is accumulating which shows that staphylococci resistant to this antibiotic will soon be common, especially if it be used as indiscriminately as has been the case with the other antibiotics. Dowling and Lepper,[3] in Chicago, have presented a paper in which they describe a most illuminating study carried on at a Chicago hospital. On a given date, all prophylactic and therapeutic use of penicillin at this hospital was discontinued and erythromycin was substituted. Cultures from

*Presented at a meeting of the Newport County Medical Society, at Newport, R. I., December 2, 1953.

all sources in the hospital taken at that time showed eighty per cent of the staphylococci cultivated to be penicillin resistant and none to be resistant to erythromycin. At the end of six months, during which erythromycin was used in place of penicillin, cultures were again taken and it was found that the organisms isolated were *eighty per cent of them resistant to erythromycin* and fifty per cent to penicillin. The lesson is clear. Intensive application of any effective antibiotic that has yet been discovered leads to the survival of highly resistant and dangerous staphylococci. The general and indiscriminate use that has been made of all antibiotics in the treatment of all sorts of conditions, many of them inadequately studied, is causing such a widespread appearance of resistant cocci that we are faced with a situation which is, to say the very least, a clear and present danger of major proportions.

References

[1]Antibiotic Resistance of Pathogenic Staphylococci. Finland & Haight. Arch. Int. Med. 91:143 February 1953

[2]Fatal Staphylococcus Enteritis Following Penicillin and Streptomycin Therapy. Favilie and Kendall. JAMA 153:90 September 12, 1953

[3]To be published

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ship, if any. Furthermore, we should have a definite answer to the even more important question of whether or not smoking has an appreciable influence on life expectancy.

If smoking proves to be a major cause of lung cancer, then we have found a means of preventing many, if not most, cases of the disease. However, while studying smoking, we are not forgetting the possibility that one of the other factors, or a combination of factors may be responsible. We think that at least we have narrowed the field of likely possibilities and we are determined to find the answer.

What I have told you is just a brief sketch of a few of the subjects being worked on in cancer prevention. There is a tremendous amount that needs to be done, but unfortunately there is an acute shortage of research workers with the specialized training needed in this field. To meet this need, Yale University established this year a new program for predoctoral and post-doctoral training of research workers in the field of biometry and statistical epidemiology of the chronic and old age diseases. The American Cancer Society is cooperating in the program and is providing funds for fellowships for people who wish to conduct cancer research along these lines.

From time to time the American Cancer Society is criticized for publishing frightening facts about cancer to be read by the general public. These critics ask why we don't emphasize the "bright side of the picture." The fact is that cancer is a frightening disease and we would be deceiving the public if we made it appear to be otherwise.

To my mind, progress being made in cancer prevention is bright indeed. Undoubtedly, the goal will be hard to reach. It may take many, many years and many heartbreaking disappointments. But the vision of what may come to pass through our efforts gives the inspiration to carry on, no matter what difficulties arise.

TREATMENT OF INTRA-ORAL CANCER

EDWARD S. CAMERON, M.D.

The Author. *Edward S. Cameron, M.D., of Providence; Member, Consulting Staff, R. I. Hospital.*

SUMMARY AND CONCLUSIONS

RADICAL SURGERY is presently more generally used in the treatment of intra-oral cancer in this country than in the period ten or twelve years ago. Procedures combining neck dissection, excision of intra-oral lesions, and often including hemi-mandibulectomy, or some type of partial mandible resection are called combined operations. These are operations of continuity as in surgery of breasts, G.I. tract, uterus, etc., and may offer the best chance of cure in many cases.

Surgery and radiation should not be competitive, but collaborative. Ordinarily, we dislike heavy radiation near bone in these cases because of: (a) Resulting bone necrosis; (b) Difficulty in killing cancer cells about bone; (c) It is usually harder to determine if and when the local lesion is controlled, than after surgical excision; (d) Radiation has no appreciable effect on the lymphatic drainage area.

Lesions involving the base of tongue and fauces may be satisfactorily treated by radiation plus neck dissection when indicated.

Surgery when it can be used as a primary treatment, is more definitive and allows an earlier evaluation of result and a more prompt metastatic offensive.

The size of the primary lesion bears an all important relation to cure. In a study of 95 tongue lesions from Rhode Island Hospital Tumor Clinic 1949,* 14 had lesions less than 2 cm. overall. The 3 year cure rate in these 14 cases was 50%, whereas the 3 year rate in the remaining 81 cases, whose lesions were greater than 2 cm. overall, dropped to about 10%. The 3 year cure rate for the entire group of 94 was 15.8% and in 84 cases followed for 5 years there were 11.9% cures.

Indications for Combined Operation in Intra-oral Cancer

1. Lateral tongue lesions spreading to floor and mandible.
2. Floor of mouth involving mandible.
3. Buccal lesions overlying mandible.
4. Alveolar mandibular lesions.
5. Antero-lateral cancer of tongue with homolateral nodes at onset.

Contra-indications for this type of Surgery.

1. Extensive infiltrating local lesions.
2. Bilateral neck metastases at start of treatment.
3. Masses of fixed metastatic nodes, unilateral.
4. Distant metastasis.
5. Lesions graded high, pathologically.
6. Base of tongue, and faucial regions.
7. Hard palate lesions, with some exceptions.

Illustrative Cases

The following four cases are given briefly, as illustrating methods of treatment used for some of the lesions mentioned above. It is not the intent to infer that the favorable results to date in these few cases are samples of treatment results in general for intra-oral cancer at Rhode Island Hospital.

1—Base of Tongue and Fauces—2 Cases

B.D., #349324. Male. Age: 52.

Diagnosis: Epidermoid Cancer posterior portion of tongue and anterior pillar.

Lesion a little less than 2 cm. overall.

Pathology: Grade II.

July 25, 1941: Teeth extraction.

August 5, 1941: Radon seeds to lesion of tongue and faucial pillar.

October 7, 1941: Node has developed in left upper neck. Operation: Lateral neck dissection, left, including internal jugular and S.C.M. muscle. Radium needles to a suspicion area upper part of wound beneath the jaw angle.

Pathology: Epidermoid Carcinoma metastatic to neck.

This patient last seen June 13, 1951. Examination at Tumor Clinic reveals no evidence of recurrence. Almost a 10-year survival at this date.

F.B., #419502. Male. Age: 62.

Diagnosis: Cancer Floor of Mouth, 2 x 3 cm. overall, involving anterior pillar of tonsillar fossa and tongue, to gingiva, left.

Pathology: Epidermoid, squamous, grade III.

Discussion at Rhode Island Hospital Surgical Conference February 1, 1952. Subsequent examination reported as of July 8, 1953.

*Thomas Perry, Jr., M.D., and Edward S. Cameron, M.D.; Epidermoid Carcinoma of the Tongue, Rhode Island Hospital Medical Journal, December 1949—Vol. 32:663-669.

January 15, 1947: Radium needles to intra-oral lesion.

March 25, 1947: Radical neck dissection, left.

Pathology: Squamous Carcinoma, metastatic.

December 26, 1951: No evidence recurrence locally or either side of neck.

Practically a five-year survival at this time.

II—Extensive Intra-Oral Lesion with Homolateral Neck Metastasis—One Case

J.C., #405000. Male. Age: 73.

This man showed an extensive labio-gingival sulcus ulcer, with extension toward posterior lateral tongue, right side. Also, a 3.5 cm. overall, clinical neck metastasis, submaxillary region, right.

Pathology: Grade II, squamous carcinoma.

He was operated upon March 16, 1946, in a one stage procedure. Radical lateral neck dissection, right, was done and then radium needles were inserted into the mouth lesion.

Radium dosage received: 1850 mg. hours.

Pathology of Neck Dissection: Inflammation of salivary glands; lymph-adenitis.

At this time, February 1, 1952, this man who is now 80 years of age, shows no evidence of intra-oral or metastatic cancer. The right alveolar ridge at the previous cancer area, shows a 1.5 cm. notched defect, which is now covered by normal appearing mucous membrane. He has kept a 2x1.5 cm. sequestrum, which was extruded spontaneously about 18 months after radiation.

This method of treatment, combining neck dissection for clinically positive homolateral nodes, with interstitial radium to the local lesion, may be used in some cases.

The clinically positive neck metastasis were properly considered cancerous in conjunction with the pathologically positive primary lesion. It is the writer's feeling that the pathologist may sometimes miss tiny islands of cancer cells in neck dissection specimens, unless very complete serial sections are made, and this routine may not always be practical.

III—Lesion of Anterior Floor of Mouth, and Tongue, with Extension to Submaxillary Region —One Case

S.J., #474707. Male. Age: 56.

May 4, 1950. Examination shows tongue partially fixed by irregular 1.5 cm. lesion to right of phrenum. Extension on to proximal gingival surface and a 3.5 cm. convex, firm tumor in right submaxillary region.

PLAN OF TREATMENT PROCEDURE

Biopsies, and after paraffin sections, combined operation, if cancer found.

Biopsy: Epidermoid Carcinoma, Grade II.

Operation May 16, 1950: Combined Operation. (a) Right lateral neck dissection; (b) Lip transected lateral to mouth tumor and mandible divided at this point. (This step allows wide exposure and facilitates the intra-oral procedure.) (c) Lesion of mouth, tongue and jaw excised with a good margin, the inner table of mandible at cancer area being resected with electric saw. The complete intra-oral lesion and tissues of neck dissection then removed en bloc. (d) The ends of jaw were wired through holes previously drilled. The mouth defect was closed, satisfactorily, using a portion of mobilized tongue to accomplish closure.

The neck wound was closed without drainage and a Wallace collar plus dressing applied.

Pathology: Epidermoid Carcinoma Grade II floor of mouth, tongue, and extension to gum, with infiltration toward salivary gland tissue. Section of several lymph nodes of neck specimen show lymph-adenitis without cancer.

Because of enlarging, firm, submaxillary gland on left, a lateral dissection of left neck was done December 6, 1950. The internal jugular was not taken and a portion of S.C.M. muscle was left. Submaxillary gland was twice normal size and very firm.

Pathology: No indication of metastatic malignancy.

Pathological Diagnosis: 1. Sialadenitis. 2. Lymphadenitis, hyperplastic.

July 8, 1953. Examination of mouth and neck at this time show no evidence of recurrence. Now three years since primary operation.

IV

The last case reported, S.J., gives a quite satisfactory method of procedure for lesions of the anterior floor of mouth. Very often, in this region, the structures of the upper neck are involved through direct extension from the primary tumor. Combined operation seems especially indicated in these cases and this type of operation is presently standard procedure for such lesions at the Rhode Island Hospital.

When the cancer does not actually involve the jaw, but extends on to the gingival surface, partial resection of inner table at a good margin from the lesion, offers a satisfactory operation in place of complete resection with disarticulation of half the mandible. This partial mandibular resection is especially desirable in lesions near the midline in the type described above.

GOITER MEETING IN BOSTON

The 1954 meeting of the American Goiter Association will be held at the Somerset hotel, in Boston, on April 29, 30, and May 1.

The program for the three-day meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland. For further information direct inquiries to Dr. John C. McVlintock, Secretary, 149½ Washington Avenue, Albany, N. Y.

MEDICAL PUBLIC RELATIONS*

ALFRED L. POTTER, M.D.

The Author. *Alfred L. Potter, M.D., President of the Providence Medical Association, 1953.*

AT THE last meeting over which he presides and before he passes on the gavel to his successor it is the duty of the retiring President to use the occasion to give counsel for the future out of the profundity of his year's experience. With the passage of this milestone he becomes an elder statesman, an aged Nestor, possibly wiser with the years, usually garrulous, and often boring. However that may be, it is your duty to listen as it is mine to speak.

The text of my remarks and one which sums up the state of our medical public relations is a quotation of that sterling character in Stevenson's TREASURE ISLAND, Billy Bones, who says, "Doctors is all swabs."

Many of us have been increasingly disturbed of late by a deterioration of medical public relations. Painfully concrete evidence of this is the skyrocketing of your professional liability insurance rates because of an increasing recourse to litigation by malcontents. Pro Bono Publico writes more frequently and acridly in the Letters to the Editor columns of the press decrying some real or fancied dereliction by the medical profession. To their credit our own medical journals have been foremost in condemning fee splitting, ghost surgery, and exorbitant fees, but these efforts to clean our own house have been taken up by the few sensation-seeking members of the press and their yelping has resounded out of all proportion to the true state of affairs. Politicians in seeking a scapegoat for economic ills which bear hard on us all have often singled out the cost of medical care as a chief cause of the high cost of living. It is natural that their allegations find ready credence with many.

Sickness and accidents are destructive and often catastrophic evils, inconvenient, disheartening, and expensive to the afflicted, and although the doctor may aid in the recovery or give comfort, he is nevertheless associated in the mind of the patient with a calamity. In only a few instances, as when a man gets new vision by glasses or a mother leaves a hospital with a baby in her arms, does the physician seem at best to do anything but return the patient to his former state. There is nothing to show for the receipted doctor's bill but a memory of an unpleasant episode. In fact "doctors' bills" have become a term which includes hospital expenses, drugs, roses for the sick room, and even loss of income while laid up. Of all these, however, the doctors' have been the slowest to rise in cost, and is proportionately less than ever.

Although the chance of recovery and speed of return to good health have been miraculously increased in the past generation out of all proportion to the total medical expense and especially to his doctor's charge, this is forgotten in the general discontent with his economic plight. What better whipping boy than Medicine? And it is only fair to say that in some instances the strokes are merited.

This public dissatisfaction with our craft is not new. Permit me another quotation: "Medicine is the most distinguished of all the arts but through the ignorance of those who practice it, and of those who casually judge such practitioners, it is now of all the arts the least esteemed. The chief reason for this error seems to be this: Medicine is the only art which our states have made subject to no penalty save that of dishonour, and dishonour does not wound those who are compacted of it." This modern sounding comment was written more than 2,300 years ago and is ascribed to that Greek physician, Hippocrates, to whose oath most of us subscribed when we became doctors of medicine. In this same writing, "Law," he outlined the requirements of a practitioner of the art naming natural ability, place of instruction, instruction from childhood, diligence, and *Time*. Like wine and cheese a good doctor takes time in the making.

Of these Hippocratic requirements the possession of natural ability is determined by the student's own insight, by the competition of premedical training, and by the gantlet of aptitude tests and interviews which the candidate must survive. With this natural ability, with the opportunity to study medicine, and with diligence the student becomes a doctor of medicine, and on fulfilling the legal requirements is licensed by the state to practice medicine, to deal with life and death, to give

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*The Presidential Address delivered at the 107th Annual Meeting of the Providence Medical Association, held at Providence, R. I., January 4, 1954.

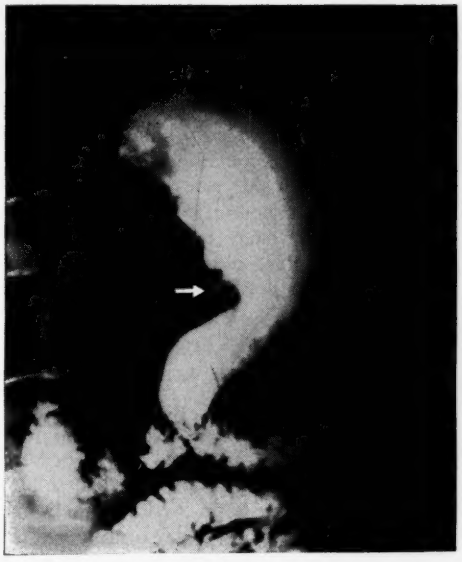

Fig. 1 "Roentgen examination . . . revealed the ulcer to be very much in evidence."

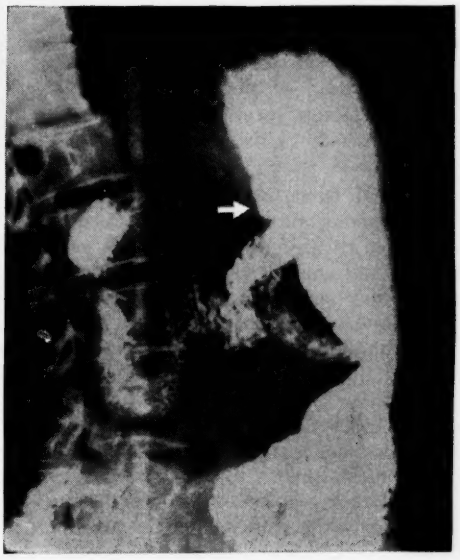

Fig. 2 In ten weeks "the ulcer niche was no longer in evidence roentgenologically or gastroscopically."

Clinical Evaluation of Pro-Banthine®

The case report described below offers significant evidence of the high potency in low dosage of the new, well-tolerated anticholinergic agent, Pro-Banthine.

"M. D., female, aged 48, had a posterior gastrojejunostomy 14 years ago for duodenal ulcer. The patient was fairly well until nine months ago when severe, intractable pains occurred. She was hospitalized and a subtotal gastrectomy was done.

"She remained well for only a few months and was referred to us because of recurrence of very severe pain and marked weight loss. Roentgen study revealed a fairly large ulcer niche on the gastric side of the anastomosis.

"The patient had been on various types of antacids and sedatives without relief from pain. She was given 60 mg. of Pro-Banthine q.i.d. and within 72 hours was able to sleep through the night for the first time in weeks.

"At the end of two weeks of such treatment the patient had absolutely no pain and felt that she had been 'cured.' Roentgen examination at this time revealed the ulcer to be very much in evidence (*Fig. 1*). Much persuasion was necessary to make the patient realize the importance of maintaining her diet and therapy.

"Ten weeks of controlled regulation was necessary before we were satisfied that the ulcer niche was no longer in evidence roentgenologically or gastroscopically (*Fig. 2*).

"She has been maintained on 30 mg. [q. i. d.] of Pro-Banthine for almost five months with no recurrence of symptoms."[1]

Pro-Banthine (*brand of propantheline bromide*), the new, improved anticholinergic agent, is more potent and, consequently, a smaller dosage is required and side effects are greatly reduced or absent. It is available in 15 mg. tablets as well as in tablets (15 mg.) with Phenobarbital (15 mg.) and in 30 mg. ampuls.

Peptic ulcer, gastritis, intestinal hypermotility, pancreatitis, genitourinary spasm and hyperhidrosis respond effectively to Pro-Banthine, orally, combined with dietary regulation and mental relaxation. G. D. Searle & Co. *Research in the Service of Medicine.*

1. Schwartz, I. R.: Personal communication, Feb. 9, 1953.

MEDICAL PUBLIC RELATIONS

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counsel in some of the most profound human relationships, to be trusted as few men are. Probably a higher proportion of these young men, these newly licensed doctors, meet these tremendous tests which life will hold for them than does any other group of men.

The physician has a position which is unique in the trust, responsibility, and almost veneration which is given to the good doctor. His personal freedom and self employment are blessings known to few these days, although when the demands are great that these are blessings may seem debatable. This freedom and honor entail inescapable duties. Some forget this and accept the one but not the other.

We are doctors of choice, our own choice. The practice of medicine is still a calling, a consecration. Probably for this reason in the more than 2,300 years since Greek medicine advanced the art beyond the realm of the magician and the priest, there have been no penalties to keep the erring physician in order except an unwritten code of good form and the physician's own associates and guilds. It is not for the mercenary. All the great medical discoveries have been freely given to the world, to all doctors without copyright or profit. There are no national boundaries in medicine. Of all professions it alone strives to eliminate the source of its livelihood, to wipe disease, accidents, and human suffering from the face of the earth.

In the nature of things some doctors will fail to live up to their early ideals, some will become greedy, dishonest, unethical in their relations with their fellow doctors and with the public. To deny this would be to place man as high as the angels. What licensing board can foresee the future of the candidate? Which of these young doctors will stagnate, never be better than the day he hung out his shingle? Which of these bright young men will develop mental aberrations, subclinical psychopathic tendencies which may not be overt enough to incapacitate but which will completely alter his outlook on society? Economic pressure may force some to sell out. His own health, physical or mental, may prevent his holding to the true course. As in Hippocrates' time, so today, dishonor is the only penalty for this. But dishonor by whom?

There has not been and there is not now an authority empowered to reappraise, warn, or when proper, deprive these failures of their privilege to continue to practice, unless they really break the law and are convicted. Only other doctors can appraise the professional competence of a doctor, but unless a man may fail of promotion or be dropped from the staff of a hospital, professional incompetence is not penalized except as reflected in his practice. He may continue to beguile a gullible public which is often unable to choose between the good and the bad doctor, and he may be a success economically. The public cannot judge, and ethics has properly sealed our lips as far as any criticism of the individual by individual doctors. A serious breach of ethics might deprive a doctor of his medical society membership, but unless he commits a felony such as drug peddling or commits an abortion, which under our rules of evidence is almost impossible of conviction, his license to continue in practice is not revoked. Once licensed, his position seems impregnable, and as for dishonor, as Hippocrates said, it does not wound those who are composed of it.

"An olde Proverbe says,
That byrde ys not honest
That fouleth hys own nest."

Like the cuckoo, which lays its eggs for other birds to hatch, these parasites are a burden on all honest doctors. We have protected these birds beyond all reason, we have condoned their malfeasance, and, to depart from our ornithological metaphor, now these few rotten apples in the barrel have given all the apples the same bad odor.

In 1816 Stephen Decatur proposed a toast: "Our country; in her intercourse with foreign nations may she always be in the right, but our country right or wrong." This has seemed to be our attitude toward every doctor, good or bad. I like better a change made by Carl Schurtz in Congress in 1872, "Our country, right or wrong; when right to be kept right, when wrong to be put right." Doctors have always been clannish, have a language of their own, live lives different from other men, and seem to go to great lengths to protect the erring guild brother from censure or discipline. It seems to me that we are now under a greater obligation than to a craft or guild. We are not in the Middle Ages. We must be citizens first of all and must stand up and be counted on the side of right.

Only his fellow doctors, it seems to me, can properly judge, and either condemn or exculpate a doctor. It seems that some procedure could and should be found to discipline those few who prostitute our calling and bring us all into disrepute with the public, those few who falsify disability and insurance claims, give questionable evidence in drunken driving charges, who charge excessive fees, who operate for minimal indications, who split fees by some subterfuge or other, and who are unethical in their relationships with other doctors. It is difficult for our association to be at once the prosecuting attorney, judge and jury. Your Committee on Ethics and Deportment is a most important way of getting redress of grievances by the public and by other doctors except for outright civil and criminal cases. It is a potent force for good in public relations, and the difficult unseen work of this committee merits

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MEDICAL PUBLIC RELATIONS

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our gratitude. It should be given more power and should be resorted to more often. Our Committee on Public Information is helping the press to know us better, and makes it easier to meet the proper demands of the press.

No Hogarth or Rowlandson now caricatures our profession, no Voltaire or Molière holds us up to public scorn. Compared to them our present day critics are Lilliputian. It is interesting that we of later generations see that much of that harsh criticism was deserved. It may be so of us. We must realize that our emotions are stirred and that we are not impartial judges of the comment of our day. The press does praise our good works when it merits praise. And Stevenson who made Billy Bones say, "All doctors is swabs," wrote a tribute to our profession which puts us on so exalted a plain that we cannot read it without inward embarrassment unless we think of its being written of the great men in medicine, the Lazears, the Noguchis, the Schweitzers.

He wrote: "There are men and classes of men that stand above the common herd: the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarelier still the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization. Generosity he has such as is possible to those who practice an art, never to those who drive a trade; discretion tested by a thousand secrets, tact tried in a thousand embarrassments: and what are more important, Herculean cheerfulness and courage."

That would have been a good peroration but I should not close leaving you smugly self-satisfied. Stevenson lived before our age of specialization, and he wrote those words not of the doctors in the laboratory carrying out the necessary and complicated techniques which have been the glory of and have brought the successes of modern medicine, nor of the specialists, necessary because of the increased complexity of our art, but about the doctor he knew, whom we call the "family doctor." He was the doctor most of us looked up to when we were young. There is a move to modernize this term, family doctor, as being old fashioned, by calling him "personal physician." In his own self-depreciating way he used to call himself, "just a family doctor," and the thoughtless accepted his self disparagement. The only good thing about this term, personal physician, lies in its recognition of the need and yearning which the patient feels for someone who will give him a continuing close doctor-patient relationship and will take on that unbroken mutual responsibility and affection. The general practitioner, the family doctor, had a most important advantage. He had a mutual acquaintance with, a neighborly understanding of, the daily lives of his patients, their antecedents, their everyday problems. A term has been coined to express a truism which the old doc took for granted. "Psychosomatic," which reminds us that the patient's emotions, worries, joys, disappointments, and fears are reflected in his bodily functions and physical ills. Our old-fashioned doctor was able to treat the whole man because he knew the whole man. He lived with him, watched him and his children grow up, was part of his community and his life.

The patient realizes the occasional need of a specialist in special circumstances, but resort to such counsel should not be, as it too often is, the unguided decision of the patient. The vast majority of ailments can be cared for by the good general practitioner. Too few people when well and of calm mind elect and select a doctor, a family doctor, a general practitioner, a personal physician to guide them in their medical problems. We should all encourage the public to return to this ideal. We should restore the prestige of the family doctor.

It is heartening to find more and more often among the medical students of today this aspiration to be good well-rounded general practitioners, eager to make their weight felt as doctors and citizens, to lead a full life.

This brings up another point in public relations. As citizens I believe doctors have been derelict. Their advantages of education and public trust should require them to take the leadership in public service in at least those fields touching medicine in which it is expected that doctors should be deeply concerned — air pollution, the condition of our parks and recreation centers, juvenile delinquency, the contamination and filthiness of our rivers, waterfronts, and beaches, contamination of shellfish and other foods, and an interest in our educational problems. The doctor must come down from his ivory tower into the streets and market place. He must become the outstanding citizen he used to be and again take part in neighborhood activities, local politics, the church, and education.

In conclusion, to try to regain the good medical public relations which the past generations of doctors enjoyed:

1) We must return to the ideals which were ours when we entered Medicine; we must rededicate ourselves to service.

2) We must more closely follow the letter and the spirit of our professional code of ethics both as to fellow doctors and the public. It was designed for the welfare of the public, the patients.

3) We must be less resentful of honest criticism and look for its causes.

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The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society
106 Francis Street, Providence, Rhode Island

TELEPHONE LISTINGS

At its recent meeting our House of Delegates took time to issue rulings regarding telephone (and other) directory listings for physicians. Every member of the Society should take heed of the decisions taken in the best interests of the entire profession.

The house reaffirmed its decision of a year ago that no member shall list his specialty after his name in the classified section of the telephone directory, or any other non-medical directory, *except* that when identical last names of physicians *may* be a cause of inconvenience to the public the specialty listings *may* be given.

It also ruled that the new proposal of the telephone company to provide special type listings, at a special premium charge, in the alphabetical section of the directories should not be accepted by members of the Society.

In our restricted geographical area, specialists are soon identified by the public, and where there is any doubt a call to one of our hospitals, or the medical library, will provide the answer. In addition, the Medical Bureau of the Providence Medical Association, operating on a 24-hour basis, can always furnish information about any specialty listings on the basis of the directory published by the Society.

AMA DUES

After three years of experience the American Medical Association is gradually resolving many of the conflicts that invariably arise in the maintenance of records on more than a hundred thousand physicians. The assessments for 1954 have been mailed to all Rhode Island Physicians by our own society merely as a convenience to the AMA. Payments should be made to the American Medical Association (in the amount of $25) but checks and bills should be returned to the Rhode Island Medical Society for clearance.

In spite of our repeated requests to send dues to our own office so that the member may be properly vouched to the national association as a member in good standing, some physicians send their payments directly to Chicago. Such payments are immediately referred back here by the AMA, thus adding to the work involved in the collecting and recording of dues.

A few physicians failed to pay 1950 dues, and therefore at the interim meeting in St. Louis in December the House of Delegates voted that anyone who failed to pay his 1950 dues and who was suspended for such delinquency, may be reinstated during the first six months of 1954 by payment of 1954 dues only. Should any such individual fail to

continued on next page

pay his 1954 assessment by July 1 he will continue to be considered delinquent.

Some members do not wish to receive the JOURNAL OF THE AMA. Provision is made for the substitution of one of the specialty journals instead, and members need only to check the journal desired under the special listing on the reverse side of the dues bill sent out by our Society.

DIABETES FAIR

The preliminary report on the diabetes fair held under the auspices of the Society's committee on diabetes indicates a continued vigorous public interest in the detection of this disease. The fair this year was held in the auditorium of the Providence Journal Company where more space was available than at the medical library.

A total of 639 persons registered during the one day of free examination, and of these 465 had chest x-rays of which three proved suspicious. The cooperation of representatives of the nursing, chiropody and dietetic associations made the fair one of the best ever conducted locally.

Final tabulations have not been made in the statewide detection campaign, but the preliminary figure of 10,133 exceeds any previous year. The use for the first time here of Dreypak aided materially in the campaign. The Providence School department experimented with this new method of testing, using 1,949, and the results showed 58 suspicious cases and three positive.

As an activity supported by the Society morally and financially, the annual diabetes detection campaign is an example of outstanding public service in the interest of better health.

A GOOD CHOICE

The selection of Dr. Charles Farrell of Pawtucket as a member of its important national committee on prepayment medical and hospital plans for the next three years was a good choice by the Council on Medical Service of the American Medical Association.

As a member of our Society he has been an outstanding worker, and he is exceptionally well informed on medical-economic and medical-sociological issues. He is presently a member of both the Physicians Service and the Blue Cross boards of directors here, and in addition he chairmans the Society's health insurance committee that has supervised our operations with the insurance industry in promoting voluntary medical and surgical coverage.

Nationally, Doctor Farrell has served for several years as our delegate to the AMA House of Delegates, and during his terms he has been named to reference committees to review proposals vital to the profession. Last year he also had the distinction of serving as president of the Association of American Physicians and Surgeons.

Medicine is fortunate that there are physicians like Doctor Charles Farrell who give unselfishly of their time and energy to work in the interests of the entire profession in order that it may collectively render even greater service to people throughout the country.

DR. MEYER SAKLAD HONORED

The high professional standing of anesthesiology in Rhode Island is due in no small measure to the efforts of Dr. Meyer Saklad. Many honors have come to him for his work and it is with much pride that we belatedly report his election as President of the Board of Directors of the American Board of Anesthesiology. The election took place late last fall in the Midwest, and to our knowledge was not reported in the local press, and we would probably never have learned of the honor (certainly not from Doctor Saklad) had we not spotted his photo on the front cover of the NEWSLETTER of the American Society of Anesthesiology.

For many years he has served on the board of directors of the national organization and he has rendered outstanding service to it in his capacity as chairman of its committee on examinations, and in activities dealing with scientific and statistical matters. We know he will wear his presidential mantle well, and unobtrusively, as he continues his leadership in the training of anesthetists.

ANTI-ENZYME TOOTHPASTES

The advertising hucksters who have dazzled the public on the superior ability of the so-called "anti-enzyme" toothpastes took a pasting themselves late last month when the Council on Dental Therapeutics of the American Dental Association issued a statement emphasizing the Association's skepticism concerning the entire anti-enzyme field of dentrifices.

In its statement, following its study by the committee, the dental council reported that it had reviewed the evidence and had found no satisfactory clinical proof of the effectiveness of these dentrifices against tooth decay, and it expressed the doubt that a dentrifice containing sodium N-lauroyl sarcosinate will prevent the occurrence of a significantly low pH level on the tooth surface.

It is to be regretted that the clinical review of the professional organization which has only the best interests of the dental health of the public at heart, will get insignificant publicity in the same newspapers that readily accept the flamboyant advertising of the so-called wonder toothpastes.

DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

The 107th Annual Meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, January 4, 1954. The meeting was called to order by the President, Dr. Alfred L. Potter, at 8:30 p.m.

Annual Report of the Secretary

Dr. Michael DiMaio read his annual report, which was received and placed on file.

Annual Report of the Treasurer

Dr. Robert G. Murphy, Treasurer, read his annual financial report for 1953, which was received and placed on file.

Report of the Executive Committee

The Secretary reported the following actions by the Executive Committee:

1) It reviewed the financial report of the Treasurer for the year 1953, and it voted to approve the Treasurer's proposed budget for 1954, which parallels that of recent years, and it also voted that it would recommend to the Association that the annual dues for 1954 be $20 for active members and $5 for associate members.

WILLIAM J. O'CONNELL, M.D.
President, 1954
THE PROVIDENCE MEDICAL ASSOCIATION

Action—It was moved that the recommendation of the Executive Committee be approved. The motion was seconded and adopted.

2) The Executive Committee voted to recommend to the Association that if the polio validity test, planned on a nationwide basis, includes the greater Providence Area, the Association record its cooperation and support of the program, and that it urge its members to assist in the test on a voluntary basis if called upon to do so.

Action—It was moved that the recommendation of the Executive Committee be approved. The motion was seconded and adopted.

3) The Executive Committee has reviewed the applications and supporting data received from the following physicians, and it recommends them to the Association for election as active members: Carmelo Addario, M.D., Walter Neil Meisler, M.D., Paul Barney Metcalf, M.D. It was moved, seconded and adopted that these men be elected.

Presidential Address

Dr. Alfred L. Potter delivered his Presidential Address on the subject of "Medical Public Relations," a copy of which is made a part of the official minutes of this meeting.

Election of Officers for 1954

The Secretary reported that there had been no counter nominations to the slate of Officers nominated by the Executive Committee and submitted to the membership in advance of the Annual Meeting.

It was moved that the slate of Officers and Delegates to the Rhode Island Medical Society nominated by the Executive Committee be declared elected to serve the Association until the next Annual Meeting. The motion was seconded and adopted.

Introduction of New President

Dr. Potter named Drs. Edwin B. O'Reilly and Frederic J. Burns as a committee to escort the new President, Dr. William J. O'Connell, to the rostrum. Dr. O'Connell expressed his appreciation for the honor bestowed upon him, and he called upon the members of the Association to give him their support. He then expressed the appreciation of the Association to Dr. Potter for his outstanding leadership during 1953, and he presented him an engraved gavel as a gift from the Association.

Dr. Potter introduced to the membership the other officers elected as follows:

Dr. Francis H. Chafee.....Vice President
Dr. Michael DiMaio.....Secretary
Dr. Robert G. Murphy.....Treasurer
Dr. Herbert G. Partridge.....Trustee of the Library

Reports of Committees

The President announced that any committee reports for 1953 would be printed in the RHODE ISLAND MEDICAL JOURNAL, and therefore would not be read at the meeting.

Award of Membership Certificates

The President awarded membership certificates to the following physicians who had been elected to active membership in the Association at the December meeting:

Drs. Dominic L. Coppolino, Harland M. Deos, Frederic W. Easton, III, Thomas Forsythe, Victor Glikman and Vitalijs Kaspari.

Announcements of the President

The President announced that he had appointed as a committee to prepare the Association's tribute to the late Dr. William W. Hunt of East Providence, Drs. Henry S. Joyce and Gustave Pozzi. He also announced that the Committee consisting of Drs. Paul C. Cook and Elihu S. Wing, Sr. has prepared a tribute to the late Dr. Charles S. Turner which will be placed on permanent file, and a copy sent to Dr. Turner's family.

Presentation of Roerig Company Representative

The President announced that J. B. Roerig and Company were exhibiting at the meeting, and he called upon the company's medical service representative, Mr. Elmer A. Burke, Jr., to address the Association briefly. Mr. Burke expressed the appreciation of his Company and invited the physicians to visit the technical exhibit at the conclusion of the meeting.

Scientific Program

Dr. Potter introduced as the guest speaker of the evening, Dr. George B. Thorn, Hersey Professor of the Theory and Practice of Physic, Harvard Medical School; Physician-in-Chief, Peter Bent Brigham Hospital, Boston, Massachusetts, who spoke on "Studies on the Adrenal Cortex."

Dr. Thorn's fundamental investigations on the adrenal cortex have made him the greatest authority on the subject and so was eminently qualified to speak on this complicated and important subject. He reviewed the symptoms and signs of adrenal insufficiency and discussed in detail the physiological aspects of the disease.

He also discussed in great detail the physiology and steroid response to ACTH of the cortex in adrenal hyperplasia and adrenal carcinoma. He emphasized the importance of knowing the 24-hour steroid level (17—hydroxycorticoids and 17—ketosteroids) in the urine in response to ACTH stimulation. Both urinary corticosteroids are increased by ACTH. In Cushing's Disease where the adrenal cortex is hyperactive the eosinophil count is very low and the steroid levels are high and stimulation by ACTH is tremendous.

He stated that ACTH Gel may be used for adrenal response and that an eosinophil count may be done 24 hours later.

Dr. Thorn's talk was very well received.

The meeting was adjourned at 10:20 p.m.

Attendance was 125.

Collation was served.

Respectfully submitted,
MICHAEL DIMAIO, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, December 7, 1953. The meeting was called to order by the President, Dr. Alfred L. Potter, at 8:30 p.m.

Minutes of Previous Meeting

Since the minutes of the previous meeting had been approved and are to be published in the RHODE ISLAND MEDICAL JOURNAL, the reading of them was omitted.

Announcements

The Secretary read announcements from the Rhode Island Hospital relative to its program for its Research Day on December 9, and from the Rhode Island Heart Association relative to its Anual Meeting on December 16.

Report of the Executive Committee

The Secretary reported for the Executive Committee as follows:

"At a recent meeting the Executive Committee voted to record the Association as favoring the activity of the Rhode Island Arthritis and Rheumatism Foundation in raising funds for research and for the cure of persons afflicted with these diseases.

"The Committee also recorded disapproval of bold type listings of physicians' names in the front section of the 1954 telephone directory, and dis-

continued on next page

Hear About

"THERAPEUTIC MISADVENTURES"
by RICHARD FORD, M.D.
Head, Department of Legal Medicine,
Harvard Medical School

AT THE MARCH 1 MEETING
of the Providence Medical Association

approval also of the listing of specialties in that directory.

"The Committee prepared a slate of officers of the Association and Delegates to the House of Delegates of the Rhode Island Medical Society, copy of which has been sent to each member of the Association. Counter nominations must be submitted in writing to the Secretary, signed by at least ten members of the Association, ten days prior to the Annual Meeting, to be held on Monday, January 4, 1954.

"The Committee approved of a proposal that the Association co-sponsor with the Committee on Epilepsy of the Community Workshops, Inc., an open public meeting in April, 1954 on the subject of epilepsy."

Announcement by the President

Dr. Potter announced that on Wednesday, December 9, a Medical-Pharmaceutical Forum would be held under the auspices of the Rhode Island Pharmaceutical Association and the Rhode Island Medical Society. He introduced Mr. Victor Canaipi, President of the Rhode Island Pharmaceutical Association, who spoke briefly regarding plans for the forum and extended an invitation to all physicians to attend.

Nominations and Elections to Membership

The Secretary reported that the Executive Committee recommended for election to active membership the following physicians: Dominic L. Coppolino, M.D.; Harland M. Deos, M.D.; Frederic W. Easton, M.D.; Thomas Forsythe, M.D.; Victor Glikman, M.D.; Vitalijs Kaspari, M.D.; and Gimel Ortega, M.D. It was moved, voted and adopted that these physicians be elected to active membership.

The Secretary reported that Dr A. G. Valentino had requested reinstatement as an active member of the Association. It was moved, voted and adopted that Dr. Valentino be reinstated.

Dr. Potter introduced Dr. Henry K. Beecher, Dorr Professor of Research in Anesthesia, Harvard Medical School; Anesthetist-in-Chief, Massachusetts General Hospital, who spoke on the "Use of Chemical Agents in the Relief of Pain."

Dr. Beecher brought us up-to-date on the use of pain-relieving agents. Of interest was his statement that placebos may be effective in 30 per cent of patients complaining of pain. He also stressed the importance of psychotherapy in this regard.

The maximal pain-relieving dose of morphine is around 8 milligrams and not 16 milligrams or more. He pointed out that Methodon, a synthetic product, is just as effective as morphine, milligram per milligram.

Nembutal grs. iss intramuscularly is very effective in relieving pain. Oftentimes it is better than a narcotic because it relieves apprehension. Sodium amytal is also effective in this regard.

Dr. Beecher feels that narcotics are used too freely preoperatively. He also stated that morphine and barbiturates do not lessen the amount of an anesthetic agent necessary for anesthesia.

The meeting was adjourned at 10:30 p.m.

Attendance was 92.

Collation was served.

Respectfully submitted.

MICHAEL DIMAIO, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

At the annual meeting of the Kent County Medical Society the following officers were elected: President, Francis D. Lamb, M.D.; Vice President, Briand Beaudin, M.D.; Secretary, Peter Koch, M.D.; Treasurer, John A. Mack, M.D.; Delegates, Peter C. Erinakes, M.D. and Russell Hager, M.D.; Councillor, Arthur E. Hardy, M.D.; and Alternate Councillor, Joseph C. Kent, M.D.

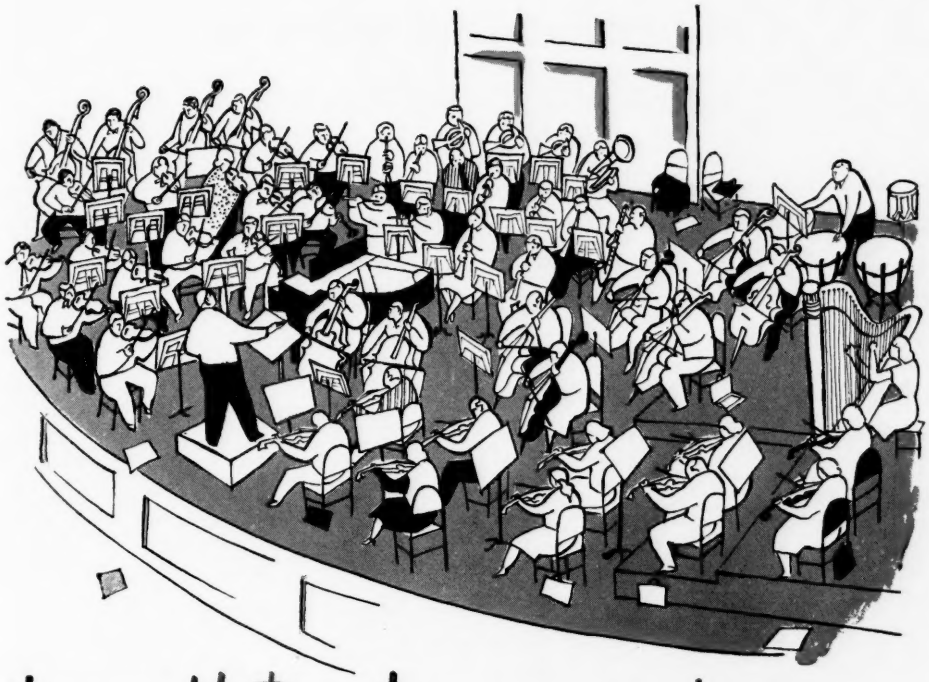
MEDICAL PUBLIC RELATIONS

concluded from page 92

4) We must protect the public and ourselves from the doctors among us who are not worthy of their calling by bringing our own delinquents before boards of review.

5) We must help the general practitioner to be better recognized by the public, and restore him to his irreplaceable place in Medicine.

6) We doctors must write and enforce stricter laws of conduct than the law currently demands or the pressure of public opinion will make the law take over.



they could stage their own symphony

. . . all the patients who represent the 44 uses for short-acting

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EVER WONDER WHY one drug should survive 23 years of clinical experience (when a lifetime for many is only about five)? Why it should account for 598 published reports? Or more than 44 clinical uses?

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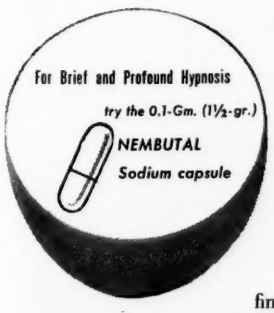
3. **There's less drug to be inactivated, shorter duration of effect, wide margin of safety and usually no morning-after hangover.**
4. **In equal oral doses, no other barbiturate combines quicker, briefer, more profound effect.**



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1-61-54

COMMITTEES OF THE PROVIDENCE MEDICAL ASSOCIATION—1954

Advisory Committee to the Community Workshops, Inc.
Clifton B. Leech, M.D., *Chairman*
Nathan A. Bolotow, M.D.
Raymond F. Hacking, M.D.
William V. Hindle, M.D.
Donald F. Larkin, M.D.
Maurice W. Laufer, M.D.
Merle M. Potter, M.D.

Disaster Committee
J. Merrill Gibson, M.D., *Chairman*
Hilary H. Connor, M.D.
William A. Horan, M.D.
Joseph G. McWilliams, M.D.
James B. Moran, M.D.
Francis W. Nevitt, M.D.
Edward I. Seltzer, M.D.

Entertainment Committee
William J. H. Fischer, Jr., M.D., *Chairman*
Nathan A. Bolotow, M.D.
Bertram Buxton, Jr., M.D.
Charles S. Dotterer, M.D.
James J. Sheridan, M.D.

Committee on Ethics and Deportment
Albert H. Jackvony, M.D., *Chairman*
E. Victor Conrad, M.D.
Frank W. Dimmitt, M.D.
Alfred L. Potter, M.D.
John G. Walsh, M.D.

Group Insurance Committee
Robert G. Murphy, M.D., *Chairman*
Emanuel Benjamin, M.D.
James H. Cox, M.D.

Committee on Legislation
Joseph Smith, M.D., *Chairman*
Frank B. Cutts, M.D.
Jacob Greenstein, M.D.
William A. Reid, M.D.
James J. Scanlan, M.D.

Advisory Committee to the Medical Bureau
John G. Walsh, M.D., *Chairman*
Irving A. Beck, M.D.
Frederic J. Burns, M.D.
Robert G. Murphy, M.D.
Emery M. Porter, M.D.

Medical Milk Commission
Frank I. Matteo, M.D., *Chairman*
Reuben C. Bates, M.D.
D. William Bell, M.D.
George Bowles, M.D.
Bertram Buxton, Jr., M.D.
Harold Calder, M.D.
John P. Grady, M.D.
Henry E. Utter, M.D.

Program Committee
Wilfred I. Carney, M.D., Chairman
Irving A. Beck, M.D.
Alex M. Burgess, Jr., M.D.
Frederic J. Burns, M.D.
Francis H. Chafee, M.D.
Edmund B. Curran, M.D.
Michael DiMaio, M.D.
Marshall Fulton, M.D.
Ferdinand S. Forgiel, M.D.
John F. Gilman, M.D.
Seebert J. Goldowsky, M.D.
Louis I. Kramer, M.D.
Alfred L. Potter, M.D.
Ernest Thompson, M.D.

Committee on Public Relations
Arnold Porter, M.D., *Chairman*
Frank D. Fratantuono, M.D.
Clifton B. Leech, M.D.
John A. Roque, M.D.
H. Frederick Stephens, M.D.

Reading Room Committee
Seebert J. Goldowsky, M.D., *Chairman*
Francis D. Lamb, M.D.
William J. Schwab, M.D.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on January 20, 1954

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, January 20, 1954. The meeting was called to order by the President, Dr. Earl F. Kelly, at 8:00 p.m.

The following Delegates were in attendance: *Kent County*—Peter C. Erinakes, Russell P. Hager; *Pawtucket District*—Edwin F. Lovering, Adrien G. Tetreault, Henry E. Turner, Howard Umstead, Harold A. Woodcome; *Woonsocket District*—Francis P. Vose; *Bristol County*—Ralph J. Petrucci; *Providence*—Charles J. Ashworth, Robert R. Baldridge, Irving A. Beck, Alex M. Burgess, Jr., Frederic J. Burns, Wilfred I. Carney, Francis H. Chafee, William B. Cohen, Edmund B. Curran, John A. Dillon, Michael DiMaio, William J. Fischer, J. Merrill Gibson, John C. Ham, Hannibal Hamlin, Albert H. Jackvony, Ernest K. Landsteiner, Robert G. Murphy, William S. Nerone, Arnold Porter, Alfred L. Potter, William A. Reid, Lee G. Sannella, William J. Schwab, Linus A. Sheehan, James J. Sheridan, George W. Waterman, Vincent Zecchino; *Officers of the RIMS*—Herbert E. Harris, Henri E. Gauthier, Earl F. Kelly, Thomas Perry, Jr.; *President, Physicians Service*—Joseph C. O'Connell; *Delegate to the AMA*—Charles L. Farrell.

Also in attendance were Drs. Francis Hanley, Robert T. Henry, Louis I. Kramer, Earl J. Mara and Stanley Sprague, and Mr. John E. Farrell, the Executive Secretary.

REPORT OF THE SECRETARY

Dr. Thomas Perry, Secretary, read his report of actions taken by the Council at meetings held since the last session of the House of Delegates. A copy of the report was submitted to each delegate and is made part of the official minutes of this meeting.

Action—It was moved that the report of the Secretary be approved. The motion was seconded and adopted.

Recommendations of the Council

The Secretary reported the following recommendations from the Council:

1. The Council recommends to the House of Delegates the nomination of Dr. Charles J. Ashworth and Dr. Charles L. Farrell to be the Society's representatives on the Board of Directors of the Hospital Service Corporation of Rhode Island.

Action—It was moved that the House adopt the recommendation. The motion was seconded and unanimously adopted.

2. The Council recommends that the House of Delegates adopt as a statewide policy the action of the Providence Medical Association in not approving of special type listing of physicians' names in the alphabetical sections of the telephone directories.

Action—It was moved that the Council approve the recommendation. The motion was seconded and adopted.

There was discussion of the question of listing of specialties of physicians in the classified section of the telephone book. The Secretary read the report of the action of the House of Delegates at its meeting on January 23, 1953, which provided that:

"No member of the Society shall list his specialty after his name in the classified section of the telephone directory, or in any other non-medical directory, except that when identical last names of physicians may be a cause of inconvenience to the public the specialty listing may be given."

Action—It was moved that the action of the House of Delegates regarding the listing of specialties of physicians in the classified section of telephone and other directories taken January 23, 1952, be reaffirmed. The motion was seconded and adopted.

Nominations for Medical Members of Physicians Service

The President called to the attention of the House that the terms of Drs. Rocco Abbate, Frank B. Cutts, Orland F. Smith and Earl J. Mara as members of the Board of Directors of Physicians Service expired this day. He asked for nominations to serve for three-year terms, until 1957, as physician members of the Board of Directors of the Rhode Island Medical Society Physicians Service.

Action—It was moved, seconded and voted that Drs. Abbate, Cutts, Smith and Mara be renominated for three-year terms as members of the Board of Directors of Physicians Service.

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HOUSE OF DELEGATES

continued from page 102

* * *

The President recessed the meeting of the House of Delegates at 8:35 p.m. in order that the Fifth Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service might be held.

* * *

The House of Delegates reconvened at 9:06 p.m.

* * *

Dr. Kelly complimented the Board of Directors of Physicians Service for their outstanding service in conducting the business of that Corporation, and he expressed the appreciation of the House of Delegates to Dr. Joseph C. O'Connell and the members of his Board.

Report of the Delegate to the A.M.A.

Dr. Charles L. Farrell, Delegate to the American Medical Association, briefly reviewed the actions taken at the Interim Meeting in St. Louis in December. He discussed in particular the problem of the matching plan regarding intern training and its effect upon the smaller hospitals. He stated that his complete report would appear in the January issue of the RHODE ISLAND MEDICAL JOURNAL, and a detailed report of the entire proceedings of the House of Delegates of the American Medical Association was published in the JOURNAL of that Association.

Action—The report of the Delegate was accepted as presented.

Report of the Committee on Veterans Affairs

Dr. Robert T. Henry, Chairman of the Committee on Veterans Affairs, briefly discussed his mimeographed report which had been sent to each member of the House in advance of the meeting. He reviewed the recommendations incorporated in the report of his Committee.

Action—It was moved that the report and the recommendations therein, as submitted by the Committee on Veterans Affairs, be accepted. The motion was seconded and adopted.

Committee on Diabetes

Dr. Louis I. Kramer, Chairman of the Committee on Diabetes, briefly discussed the preliminary report of his Committee, which had been submitted in mimeographed form to the members of the House.

Action—It was moved that the report be accepted and placed on file. The motion was seconded and adopted.

Report of the Committee on Child Health Relations

The President, in the absence of the Chairman of the Committee on Child Health Relations, called for action on the mimeographed report that had been submitted to the House by the Chairman of that Committee.

Action—It was moved that the report, as submitted, be approved. The motion was seconded and adopted.

Committee on Social Welfare

Dr. Earl J. Mara, Chairman of the Committee on Social Welfare, reviewed the relations between the Committee and the State Department of Social Welfare, citing the excellent cooperation that has existed since the appointment of Dr. Pesare as Medical Director of the Department. He expressed the opinion that much work is yet to be done with local public welfare directors in the matter of Public Assistance Aid for Medical Care.

He read a communication from Mr. Edward P. Reidy, State Director of Social Welfare, complimenting the Society and the physicians of Rhode Island for the excellent cooperation in organizing and administering the Medical Care Program within the Division of Public Assistance.

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HOUSE OF DELEGATES

continued from page 104

The complete report of the Committee is made part of the official minutes of the meeting.

Action—It was moved that the report of the Committee on Social Welfare be received and placed on file. The motion was seconded and adopted.

Committee on Health Insurance

Dr. Charles L. Farrell, briefly discussed the mimeographed report that had been sent to the House on the work of the Health Insurance Committee.

Action—It was moved that the report be approved and placed on file. The motion was seconded and adopted.

Workmen's Compensation Legislation

Dr. Stanley Sprague, Chairman of the Committee on Industrial Health, reviewed a 1954 proposal for Workmen's Compensation legislation which he understood might be presented to the General Assembly. He discussed the legislation, and he reviewed the comments on it, as noted in the special report that had been sent to the members of the House of Delegates in advance of the meeting.

The proposed legislation was discussed by several members of the House.

Action—It was moved that the Workmen's Compensation legislation, as submitted to the House at this meeting, be approved, with the corrections and additions noted in the special report from the Committee on Industrial Health. The motion was seconded and adopted.

Legislation Regarding the Reporting of Epilepsy

The Executive Secretary reported that Representative John J. Wrenn of the General Assembly wished to reintroduce legislation that failed of enactment in 1953.

There was general discussion of the ramifications of such legislation.

Action—It was moved that the Society approve of the legislation provided the reporting is limited to epilepsy. The motion was seconded and adopted.

The House authorized Dr. William A. Reid, a member of the General Assembly, to confer with Mr. Wrenn on the legislation and make known the views of the House of Delegates regarding it.

Resolution from Kent County

Dr. Peter C. Erinakes reported that at a recent meeting the Kent County Medical Society had instructed its Delegates to introduce the following motion at the House of Delegates meeting:

"That the standards of the various medical societies, and also the state requirements to practice medicine, be investigated, particularly in regard to citizenship."

The motion was briefly discussed with Dr. Erinakes who presented the views of the Kent County Medical Society.

Action—It was voted that the subject be referred to the Committee on Public Laws to report to the Kent County Medical Society.

Woonsocket District Society Resolution

Dr. Francis P. Vose, Delegate from Woonsocket, presented a resolution adopted by the Woonsocket District Society for presentation to the House of Delegates, as follows:

WHEREAS the District Society of Woonsocket recognizes the inequitable distribution of surgical fees to referring and assisting physicians who render pre- and post-operative care to the patient, and

WHEREAS many patients are hospitalized several days for diagnostic studies by an attending physician, without recompense when the case develops into a surgical problem, and

WHEREAS the Medical Payment to physicians starts on the fourth day when most medical cases are convalescing because of the efficiency of modern therapy, therefore

BE IT RESOLVED that the State Society, through its House of Delegates alter the present Physicians Service Plan to remedy the above complaints.

The motion was discussed by members of the House.

Action—It was moved that the motion be received and referred to the Committee on the Revision of the Schedule of Indemnities of Physicians Service. The motion was seconded and adopted.

Annual Registration of Physicians

The Secretary read a communication directed to the President of the Society from the Administrator of Professional Regulation stating that it was the present intention of the State Department of Health to seek legislation at the present session of the General Assembly that would require annual registration of the licensed doctors of medicine and licensed doctors of osteopathy.

He also read the proposed legislation, which would provide that all licenses to practice medicine would have to be renewed each November 1, and members failing to renew would be considered as illegal practitioners subject to the penalties provided for violation under the Medical Practice statute. A provision was also included that each licensed practitioner must carry his annual renewal card on his person at all times.

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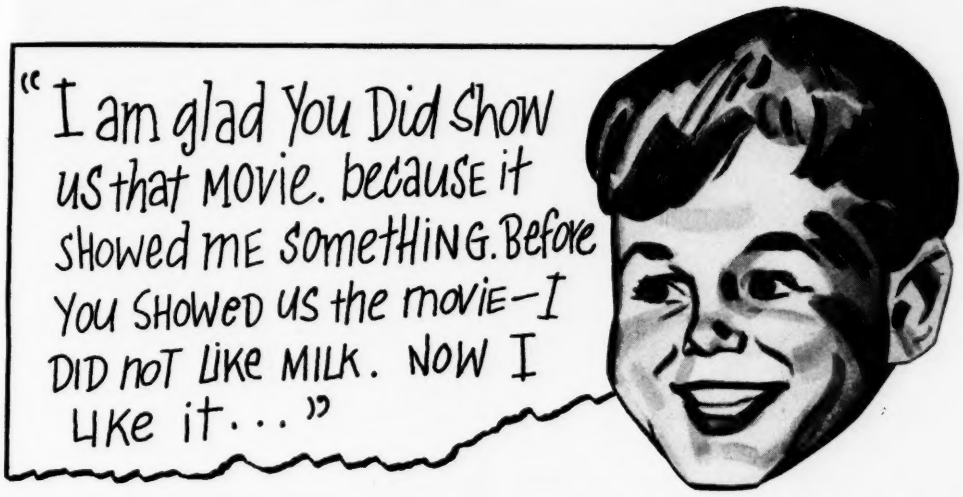

Part of a 3rd grader's letter, written after seeing Hood's Story of Milk film and forwarded to Hood's Educational Department by a teacher in Norton, Mass.

We've received many interesting comments from children, teachers, parents and civic groups as a result of H. P. Hood & Sons Educational Department programs.

This department, under direction of Dr. Thomas Stitts, is working daily to inform people about good health, and the part played by good milk and dairy products.

From children's dental puzzles, Scout lectures, posters and charts . . . lively radio and TV women's programs, health-conference exhibits and men's club lectures . . . to an extensive geriatrics program, we're convincing young and old that good health is worth working for.

If you are asked to suggest a program for any school or civic group, we have a varied supply of material, and also trained speakers. Any person interested may contact H. P. Hood Educational Department, 500 Rutherford Avenue, Charlestown . . . or call CHarlestown 2-0600, extension 420.

TYPES OF MATERIAL AVAILABLE INCLUDE:

General Nutrition program . . . Story of Milk, on slides from farm to consumer . . . Dental Health Program . . . After 35 — Then What? . . . a geriatric program for both men's and women's groups. Also posters and pamphlets are available for all age levels.

Hood

QUALITY DAIRY PRODUCTS SINCE 1846

HOUSE OF DELEGATES

continued from page 106

The proposal was discussed at length by members of the House, some of whom indicated that an annual licensing of physicians might be desirable, but the necessity of imposing severe penalties, including forfeiture of license, seemed entirely too drastic.

Action—It was moved that the proposal of the State Health Department for annual registration of physicians be approved provided all reference to medical licensure renewal and the carrying of an annual registration card is deleted from the legislation. The motion was seconded and adopted on a divided vote.

Association of American Physicians and Surgeons

Dr. Thomas Perry questioned the objectives of the Association of American Physicians and Surgeons as set forth in recent correspondence from the Association and in the magazine MEDICAL ECONOMICS. He pointed out that the House had approved the principles of this Association at its September, 1953, meeting, but he at this time did not personally favor some of the proposals as listed. There was discussion of the entire matter by several members of the House.

Action—It was moved that the subject be laid on the table for consideration at the next meeting of the House of Delegates. The motion was seconded and adopted.

* * *

It was moved that the House of Delegates adjourn. The motion was seconded and adopted, and the House was adjourned at 11:30 p.m.

Respectfully submitted,
THOMAS PERRY, JR., M.D., *Secretary*

Report of the Secretary

To the House of Delegates:

The Council has held two meetings since the last session of the House of Delegates. Among the matters resolved by the Council were the following:

1. The appointment of a Committee on Veterans Affairs by the President was approved.

2. The State Director of Social Welfare was notified of the Society's attitude regarding the State Clinic for Retarded Children.

3. Drs. Herbert E. Harris and Ernest K. Landsteiner were named as the Society's official delegates to the Boston Workshop Conference on Medical Education for the Youth of New England.

4. The Society's Committee on Chronic Illness was requested to study the Report on Old Age in

Rhode Island recently issued by the State Study Commission on this problem.

5. The reactivation of the Society's Committee for the Revision of the Schedule of Indemnities of Physicians Service established in 1951 was approved, with such additional members on the Committee as may be appointed by the President.

6. Membership of the Society in the Conference of Presidents and Other Officers of State Medical Associations was approved.

7. The Chairman of the Committee on Industrial Health was named as the Society's official delegate to the Annual Congress on Industrial Health of the American Medical Association to be held in Louisville, Kentucky, in February.

8. The President was authorized to communicate with the Governor and the State Director of Labor to notify them of the Council's displeasure with the presentation of the support the medical profession has given the State Curative Center, as related by Mr. DiPinto, Executive Secretary of the Center, in a San Diego, California, address.

9. A preliminary report from the Committee on Veterans Affairs was received by the Council, and the Committee was requested to make a supplementary report to the House of Delegates in January.

10. The sale of twenty rights accruing to the Society through its agency account supervised by the Industrial Trust Company of stocks held in the American Telephone & Telegraph Company was approved.

11. The Society's delegate to the House of Delegates of the American Medical Association was authorized to present the Society's views on the problem of securing interns for local hospitals under the matching plan at the Interim Session of the American Medical Association at St. Louis in December.

12. The Council voted not to send a delegate to the meeting of the American Medical Education Foundation in Chicago on January 24.

13. The President was authorized to name two official delegates to represent the Society at a meeting in New York in February called by the Committee on Legislation of the American Medical Association.

14. Approval was given for cooperation with a control study in Rhode Island on home accidents in cooperation with the State Health Department.

15. Approval and commendation of the Parke Davis Company magazine advertisements in the interest of better medical-public relations was voted.

16. The President was authorized to ask a member of the State Board of Examiners in Medicine

continued on next page

to attend the Annual National Congress on Medical Education and Licensure in Chicago in February.

17. Approval in principle was given a proposal for a television program to be developed and broadcast locally in Providence under the auspices of the Society, the State Health Department and the Rhode Island State Dental Society.

18. The Treasurer was authorized to send 60-day notices to seven members in arrears for 1953 dues.

19. The Board of Trustees of the Medical Library building were authorized to secure estimates for the cost of repainting the exterior woodwork of the building.

20. The report of the Child Health Relations Committee was accepted, and referred to the House of Delegates.

21. The President was authorized to appoint a special committee of three to serve as a Committee on Group Liability Insurance for Physicians.

22. Mr. Charles P. Williamson, of the law firm of Edwards & Angell, was retained as legal counsel on the same basis as in 1953.

23. The date of Wednesday, November 17, 1954, was set for the Interim Meeting of the Society, the place for the meeting to be determined upon recommendation from the Committee on Scientific Work and Annual Meeting.

24. The President was authorized to appoint for the Council a Sub-Committee on Nominations for officers of the Society for 1954.

25. A proposal that the Council approve the annual registration of physicians in Rhode Island and refer the matter to the House of Delegates for its consideration was defeated on a division vote.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

Preliminary Report of the Diabetes Committee on Diabetes Detection Week and The Diabetes Fair

Checked by	*No. Checked*	*No. Positive*	*No. Confirmed*
Physician	3,267	59	31
Diabetes Fair	111	6	....
Hospital	689	7	1
Private laboratory	139	2	0
School	3,007	35*	....
Providence District Nurses	548	16	0
Industry	1,902	19†	....
State Health Department	412	2	0
Southeastern Health Unit	44	0	....
Newport City Laboratory	19	0	....
Totals	10,133	273	34

*76 suspicious
†128 suspicious

Diabetes Detection Week was observed the week of November 15-21, 1953. The Diabetes Fair was held on November 19 at the Providence Journal auditorium. 639 guests registered, 465 had chest x-rays, of which three were suspicious. One returned for a re-check.

The Providence School Department used 1,949 Dreypak, and the results showed 58 suspicious and three positive. 44 have already been rechecked. Six of these were still suspicious and two were still positive. The neighboring school departments used 1,058 Dreypaks, of which 10 were positive, 12 were suspicious; none have been rechecked to date.

Industry used 1,389 Dreypaks, of which 16 were positive, 128 suspicious and are in the process of being rechecked.

LOUIS I. KRAMER, M.D., *Chairman*
IRVING A. BECK, M.D.
PALMINO DIPIPPO, M.D.
EDWIN F. LOVERING, M.D.
JOSEPH G. MCWILLIAMS, M.D.
AMY E. RUSSELL, M.D.
EDWARD ZAMIL, M.D.

Child Health Relations Committee

To the House of Delegates:

The general organization of school physicians in Rhode Island has been reviewed by the Committee. The wide variation of children seen and monetary compensation was noted. The lack of correlation between children examined and salary was also noted. The general inadequacy of salary received by the school physician was discussed.

General suggestions by the Committee are:

1) Frequency of examinations be standardized as suggested by booklet.*

2) Minimum salary be $500 yearly plus one dollar for each child seen per year.

3) Maximum number of pupils seen not to exceed 800 per year.

4) Committee recommended that all school children, either public or private, be examined, although the Committee was primarily interested in public school students.

5) The type of examination of children should be determined by booklet under "Procedure for school with adequate health personnel."*

6) Encouragement of association of school physicians was again discussed. It was again suggested that child health be discussed at a meeting of all school physicians, preferably at special luncheon during the annual meeting of the Medical Society.

7) School physicians, members of the Committee and the Executive Committee of the Medical Society were to be informed of these recommendations.

*Health Appraisal of School Children, Dean F. Smiley, M.D. and Fred Hein, Ph.D.

Committeee on Veterans Affairs

Report to the House of Delegates:

With more than 20 million veterans in civilian life, a number that is currently increasing every year, we are rapidly approaching the time when veterans and their families will make up the majority of the population. This situation creates some big problems and raises some serious questions in connection with the Federal government's program of hospital and medical care for veterans.

The American Medical Association has held regional meetings in various parts of the country at which state society representatives have had the opportunity to be informed of the problem. Unfortunately some news writers have attempted to construe these meetings as preparations for a battle between the AMA and the American Legion which would be resolved in the halls of Congress. Even the American Legion has been influenced into such belief, for its official magazine is reported as recently stating that "the Legion has definitely lost patience with the American Medical Association's weaving, twisting, opportunistic attacks on the Federal system of care for veterans."

There is no "weaving" or "twisting" in the stand of the medical profession on veterans care as stated through the House of Delegates of the American Medical Association. The position of physicians was expressed at the June, 1953 meeting of the AMA by the House of Delegates as follows:

"'Part One—Your committee recommends with respect to the provisions of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

"'(a) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated; and

"'(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service-connected origin, who are unable to defray the expenses of necessary hospitalization.

"'Your Committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-service-connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs.

"'The recommendation of the Committee with respect to the treatment of veterans with tuberculosis and neuropsychiatric disorders of non-service origin in federal hospitals is believed necessary at this time because of the inadequacy of local facilities designed to provide treatment for all such cases. It is the feeling of the Committee, however, that the entire question of whether the care of these patients is a local or a federal responsibility must be reanalyzed by the Congress. The rapidly expanding veteran population and the need for facilities for the remainder of our citizens afflicted with these diseases suggests that community facilities must be developed under state or local administration for the benefit of all. Preferential treatment for veterans with these non-service-connected disabilities *cannot be continued indefinitely*, in view of its detrimental effect on the health and the economy of the entire nation.'

"In conclusion, your Committee would like to stress the fact that these recommendations do not suggest any limitation or impairment of the hospitalization of medical care now available to veterans who have become physically handicapped *as a result of military service*. We are in complete accord with that program.

"Your Committee also recommends most earnestly that all of the facilities of the American Medical Association and of its constituent state and county societies be employed immediately to disseminate background information and accurate statistical data in this regard. Every effort should be made to inform the profession and the public

continued on next page

concerning the nature of the problem, the position of the American Medical Association and the reasons on which that position is predicated."

It is in connection with the final recommendation above that regional meetings of the state medical society representatives have been held. No political program or campaign against any individual or profession has been planned or even discussed. The job for the medical profession, as we see it, is to awaken the public generally to the ramifications of unlimited use of Veterans Administration facilities.

The problem was clearly illustrated in a communication from Joseph M. Dodge, Director of the Bureau of the Budget, to the Subcommittee on Hospitals of the Committee on Veterans Affairs, House of Representatives, 83rd Congress (July, 1953) in which he stated:

"A relatively limited program of hospital care for World War I veterans with non-service connected illness inaugurated 30 years ago has mushroomed into a hospital system serving 40 per cent of the entire adult male population of the country and destined in time to embrace most of the population. Two-thirds of these hospital facilities are now devoted to the care of non-service connected veterans and the proportion will steadily increase. The annual operating cost of these hospitals has increased from $70 million in the fiscal year 1941 to $500 million in 1953 and is projected to $700 million in 1975 under present policies. Another large construction program estimated at $600 million will have to be undertaken after 1960.

"These facts suggest the need for reconsidering the extent of the Federal government's responsibility toward veterans with non-service illness."

The recent action of the Veterans Administration in issuing a new addendum to the VA 10 P-10 form will undoubtedly halt some misuse of the services by veterans properly not eligible for the medical and hospital care. But the elimination of this category, while commendable in the interests of the taxpayer, would not constitute the real solution—the elimination of care for non-service-connected disabilities.

The report of the Reference Committee of the American Medical Association's policy-making body, as adopted by the House of Delegates, sets forth the basic issue clearly as follows:

"It appears that the principal confusion in this matter emanates from a failure to understand just what the basic question is. It is the belief of your Committee that the medical profession must concern itself, *not* with the number of chiselers in Veterans Administration hospitals nor with the

efficacy of the Veterans Administration in the administration of enabling legislation, but rather with the broad question of whether such legislation is sound, whether the federal government should continue to engage in a gigantic medical care program in competition with private medical institutions and whether the ever increasing cost of such a program is a proper burden to impose on the taxpayers of the country. A consideration of this problem must of course be predicated upon a concern for the health of the entire population and not just a particular segment."

The task ahead for the state medical society, the county medical association, and the individual physician, is to present the facts regarding the ever-expanding Veterans Administration medical care program. If it is to be the intention of the people of this country to accept this great expense of medical and hospital care entirely out of tax funds, the decision should be made with clear knowledge of the costs to each taxpayer, now and in the years ahead, and the wide ramifications of the policy should be set forth for all to see and hear. The medical profession recognizes the danger as indicated by the Director of the Bureau of the Budget, and it has taken upon itself the task of educating its own members and through them the public generally of the responsibility that faces every citizen in this very serious problem.

Therefore, your Committee on Veterans Affairs makes the following recommendations to the House of Delegates at this time:

1. That the Society make every effort to educate its members and the public of the ever increasing cost of the veterans administration medical care program which imposes a great burden on all taxpayers to provide services for a particular segment of the population for injuries and sicknesses not service-incurred or aggravated.

2. That each district society be asked to allocate time at one of its regularly scheduled meetings during the coming months at which the medical care of veterans may be discussed by representatives of the Society's Committee on Veterans Affairs.

3. That visual aids be secured for each district society and that eventually speakers be available in every medical area to present the profession's views on the medical care of veterans.

4. That from time to time information be published in the RHODE ISLAND MEDICAL JOURNAL on this important subject.

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Committee on Social Welfare

STATE OF RHODE ISLAND AND
PROVIDENCE PLANTATIONS
DEPARTMENT OF SOCIAL WELFARE
40 Fountain Street
Providence 3, Rhode Island

December 8, 1953

DR. EARL MARA, *Chairman*
Rhode Island Medical Society Committee on
Social Welfare
Francis Street
Providence, R. I.

Dear Dr. Mara:

I want to take this opportunity to express my sincere thanks and appreciation for the splendid co-operation which your committee has extended us in organizing and administering the medical phase of the medical care program within the Division of Public Assistance. The effective manner in which this program has been administered reflects great credit on your committee and the members of the medical profession practicing in the State of Rhode Island.

I would be very grateful to you and the members of your committee if you would convey to all members of the Rhode Island Medical Society our sincere thanks and appreciation for the splendid manner in which they have co-operated in providing minimum adequate care for eligible recipients of Public Assistance. The fact that 611 practicing physicians have actively participated assures us of the extensive participation in this program by members of the medical profession. There is no question in my mind that the vast majority of practicing physicians within the State of Rhode Island have come to a clear understanding of the intent of our program as it is organized to provide only minimum adequate care. This understanding has been achieved to a great extent through the good work of your committee in interpreting our objectives and policies.

It may be of interest to review the following statistics accumulated for the fiscal year extending from July 1st, 1952, to June 30th, 1953.

Number of participating physicians—611
Number of requests for payment—28,585
Number of requests for payment by category—
OAA—17,388 AB— 311
ADC— 9,528 AD—1,358
Total expended for physicians' services—
$174,976

It should be noted that these figures apply only to the four categories, namely, Old Age Assistance, Aid to Dependent Children, Aid to the Blind, and Aid to the Disabled. They do not include statistics pertaining to the program of General Public Assistance.

It is my sincere feeling that the practicing physicians, as an organized group, should be proud of the fact that they have effectively participated in a program designed for the adequate care of the needy. They have done so at a personal sacrifice; they have, as a result, achieved a position in which they can truthfully say that they have made a contribution toward this tremendous problem confronting any state as it relates to the care of the recipients of Public Assistance.

As you know, we are providing payment for medical services and supplies for approximately 28,000 people within the State of Rhode Island. This 28,000 represents approximately 3 per cent of the total population of the State. Let us hope that the national and state economy will be maintained at a level which will not necessitate any marked increase in the number of persons placed on Public Assistance rolls. You can readily visualize the tremendous drain that would be placed upon state funds if this total number of 28,000 people were to be increased to any appreciable extent.

Thanking you for your many courtesies and splendid co-operation, I am,

Sincerely yours,

EDWARD P. REIDY, *Director*

BOOK REVIEWS

The Editor wishes to thank the publishers for sending the following volumes to the RHODE ISLAND MEDICAL JOURNAL. These books are available at the Medical Library:

AMERICAN POCKET MEDICAL DICTIONARY. W. B. Saunders Company, Phil., 1953. 19th ed. With Thumb-Index. $3.75

JOHN AND MARY R. MARKLE FOUNDATION. ANNUAL REPORT, 1952. N. Y.

NEW AND NONOFFICIAL REMEDIES: Containing Descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1953. Issued under the direction and supervision of the Council on Pharmacy and Chemistry, A.M.A. J. B. Lippincott Company, Phil., 1953. $2.65

REPORT OF THE MEDICAL RESEARCH COUNCIL FOR THE YEAR 1951-1952. Government Publications, Lond., 1953. $1.50. (May be ordered from British Information Services, 30 Rockefeller Plaza, New York 20)

TWENTY-FIVE YEARS OF SEX RESEARCH. History of the National Research Council Committee for Research in Problems of Sex, 1922-1947 by Sophie D. Aberle and George W. Corner. W. B. Saunders Company, Phil., 1953. $4.00

PERIPHERAL NERVE INJURIES. Principles of Diagnosis by Webb Haymaker and Barnes Woodhall. 2nd ed. W. B. Saunders Company, Phil., 1953. $7.00

Many of the physicians who served in World War II in rehabilitation centers perhaps became familiar with the first edition of this now-standard work. Though it was published in the closing years of the war, it was used as a manual in many of the Army hospitals. Drawing from the great source of peripheral nerve casualties, the authors speak from first-hand knowledge. Also the abundant financial and technical resources given by the United States Army brought to the publication of this work excellent illustrations. The line drawings illustrating the numerous tests are perhaps the best part of this material.

The book limits itself to the diagnosis of peripheral nerve injuries. In times of war when physicians in large Army centers have numerous patients under their care with peripheral nerve injuries, the work devoted to diagnosis finds its greatest usefulness. But in civilian practice, the physician and surgeon must turn to a quick reference book that contains in one volume not only the essentials of diagnosing a peripheral nerve injury but, also, methods of treatment. This narrowed scope of the book is unfortunate for there is such wealth of material on diagnosis of peripheral nerve injuries that should come to the attention of more physicians and surgeons in civilian practice, especially those treating industrial accidents. This book will certainly find its place in the medical libraries and bookshelves of the specialists in neurology, neurosurgery and general surgery.

This second edition has been amplified and much new material added. In this edition the authors have divided the book into four sections starting off logically with an analysis of the anatomy of the peripheral nervous system. Good dermatomecharts are portrayed in the first section, though none of this material is based on original investigation. The second section deals with the examination of the peripheral nervous system and it can be studied to practical advantage. In the third section, the classification, causes and symptomatology of peripheral nerve injuries are discussed. The division of nerve injuries into degrees, first to the fifth, does not seem to offer any advantage over the simple clinical expression of complete or incomplete. Under the tests employed in diagnosis of nerve injuries, it is surprising to see the procaine nerve-block, for the possibility of intra-axonal damage by direct nerve blocking is a real one. The final section takes up in detail the various injuries of plexuses and peripheral nerves. This is perhaps the most useful section because it synthesizes the anatomical principles and goes on to their clinical application.

This monograph represents the most recent in the American literature on this subject. It is the so-called fruit of the recent world conflict and will find its place among the manuals of military medicine and surgery. Those who look for the graphic and now classical descriptions of nerve injuries found in Weir Mitchell's famous monograph of Gunshot Wounds and other Injuries of Nerves published after the Civil War in 1864, will be disappointed. Mitchell's monograph contained not a

continued on next page

single photograph or drawing, yet its prose makes vivid the nerve injuries therein described. For the interested student in this field, a re-reading of Mitchell's monograph and a reference to the volume by Drs. Haymaker and Woodhall provides the best background for the diagnosis and subsequent treatment of peripheral nerve injuries.

D. J. LaFia, M.D.

THE ANATOMY OF THE NERVOUS SYSTEM by Stephen W. Ranson and Sam L. Clark, 9th ed. W. B. Saunders Company, Phil., 1953. $8.50.

Upon its publication in 1920, Professor Ranson's Anatomy of the Nervous System was favorably received by medical students and practitioners and its 9th edition, revised by Professor Clark, continues to merit that favorable reception. Dr. Ranson presents the anatomy of the nervous system from the dynamic rather than the static point of view; that is to say, he emphasizes the developmental and functional significance of structure. At the inception of his neurological studies, the student is led to think of the nervous system in its relation to the rest of the living organism. Structural details, which when considered by themselves, are rather dull, tiresome and easily forgotten, become interesting and practically useful when their functional significance is explained. This method of exposition enables Dr. Ranson to remove much of the fear, if not perhaps all of the trembling, with which most of us approach the study of neurological anatomy. By the orderly presentation of his material and the clarity of his style, he conducts his readers through a difficult terrain, keeping always close to the cardinal facts of structure and function, and never losing himself and us in an abyss of infinitesimals.

Dr. Clark has brought this 9th edition completely up to date and has maintained, and even enhanced, the quality of "teachability" which has made the book so popular for so many years. There is new material on the structure and function of the cerebral cortex; on the presumptive areas for the seat of consciousness and the domain of intelligence; new data on the cerebellum, its physiology and role in the maintenance of body posture and movement; recent additions to our knowledge of the thalamus and the hypothalamus; an amplified study of pain, its structural basis and physiological nature; a careful description of cerebral angiography; an informative account of the autonomic nervous system; and lastly, a bibliography which has been greatly improved and extended.

The chapter on clinical illustrations begins with a quotation from Sir Henry Head: "The charm of neurology, above all the other branches of practical medicine, lies in the way it forces us into daily contact with principles. A knowledge of the structure and functions of the nervous system is necessary to explain the simplest phenomena of disease, and this can be attained only by thinking scientifically." To illustrate the truth of these remarks, Dr. Ranson describes fourteen clinical cases which demonstrate how necessary is the integration of the physiological anatomy of the nervous system with clinical medicine.

In 1668 Nicholas Stenson delivered "A Dissertation on the Anatomy of the Brain" in which he said, "Instead of promising that I shall satisfy your curiosity in what relates to the anatomy of the brain, I begin by publicly and frankly owning that I know nothing of the matter." At first slowly, and within the last 50 years, with increasing pace, we have traveled far since Stenson's confession of ignorance. In Dr. Ranson's book, as revised by Dr. Clark, we possess an admirable summary of our present knowledge of the nervous system which is as scientifically fascinating as it is practically useful.

John E. Donley, M.D.

IF YOU DID NOT PAY YOUR 1950 AMA DUES — Read Below

We have been notified by the Director of Records and Circulation of the American Medical Association as follows:

1. That the House of Delegates of the A.M.A. at the St. Louis session in December adopted the following resolution:

"RESOLVED, that any active member of the American Medical Association who failed to pay dues for the year 1950, and who was suspended for such delinquency, may be reinstated during the first six months of 1954 by payment of 1954 dues only.

"Should such an individual fail to pay his 1954 dues by July 1, 1954, he shall continue to be considered delinquent."

2. That the following information be made available to the district medical societies:

"We hope that you will contact immediately, any physicians in your state who were dropped from membership in the A.M.A. because of nonpayment of 1950 dues, and acquaint them with the provision of this new resolution.

"Please note that the resolution will be in effect *only* to July 1, 1954; after that date such members will again be held liable for the payment of 1950 dues if they wish to be reinstated to active membership.

"At this time we are also dropping from the membership roster those physicians who have not paid 1953 dues. These physicians are being given the option of three actions:

1. To pay $50 to cover membership dues in the A.M.A. for 1953 and 1954, to continue as an active member in good standing or
2. To pay $30 to cover the JOURNAL A.M.A. for 1953 and 1954; and be listed as a delinquent member for 1953 or
3. To pay $15 to cover the JOURNAL for 1953, to the end of the year; and be listed as a delinquent member for 1953 and the JOURNAL stopped.

"Physicians who elect either (2) or (3), will be expected to pay $10 to complete the 1953 membership fee if they wish to be reinstated as a member in a future year, along with the payment required for the current year's dues."

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